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In The Supreme Court of the United States

BRADLEY N. FROST and
WAKON IRON REDCORN,

Petitioners,

v.

UNITED STATES OF AMERICA,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Does the disposition of a privately-owned insurance company's general assets by its shareholders and officers constitute embezzlement or theft from a Healthcare Benefit Program under 18 U.S.C. § 669?

Does appellate counsel's inadvertent omission of a meritorious and dispositive argument on direct appeal, which results in waiver of the issue, constitute ineffective assistance of appellate counsel?

RULE 14.1(b) STATEMENT

A list of all parties to the proceeding in the court whose judgment is the subject of the petition is as follows:

Defendant-Appellants and Petitioners:
Bradley N. Frost,
Wakon Iron RedCorn.

Plaintiff-Appellee and Respondent:
United States Government.

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PETITION FOR WRIT OF CERTIORARI

Bradley N. Frost and Wakon Iron RedCorn respectfully petition for a writ of certiorari to review the opinion and judgment of the U.S. Court of Appeals for the Tenth Circuit.

OPINIONS BELOW

The opinion of the U.S. Court of Appeals for the Tenth Circuit, dated December 9, 2009, is officially reported at 355 Fed. Appx. 230 (10th Cir. 2009) and is reproduced at App. 1.

The order of the U.S. District Court for the Northern District of Oklahoma, dated March 4, 2009 is reproduced at App. 12.

The order of the U.S. Court of Appeals for the Tenth Circuit, dated April 28, 2010, denying Petitioners' petition for rehearing *en banc* is reproduced at App. 33.

JURISDICTION

Petitioners seek review of a judgment of the U.S. Court of Appeals for the Tenth Circuit entered on December 9, 2009. The order denying rehearing *en banc* was entered April 28, 2010. The petition is timely under 28 U.S.C. § 2102(c) and Supreme Court Rules 13.1 & 13.3 because it is being filed within 90 days after the denial of a timely petition for

rehearing. This Court has jurisdiction to review the judgment of the U.S. Court of Appeals for the Tenth Circuit pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant statutory provisions involved are 18 U.S.C. § 24(b) and 18 U.S.C. § 669, which state as follows:

> (a) Whoever knowingly and willfully embezzles, steals, or otherwise without authority converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program, shall be fined under this title or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the sum of $100 the defendant shall be fined under this title and imprisoned not more than one year, or both.
>
> (b) As used in this section, the term "health care benefit program" has the meaning given such term in section 24(b) of this title.

18 U.S.C. § 669.

> As used in this title, the term "health care benefit program" means any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and

> includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.

18 U.S.C. § 24(b).

STATEMENT OF THE CASE

Bradley N. Frost was a fifty-percent (50%) shareholder in, and the President of, Heritage National Insurance Company, Inc. ("HNIC"). Wakon Iron RedCorn was the Secretary/Treasurer and Chief Financial Officer of HNIC. HNIC was a privately-held insurance company that sold group indemnity policies, which included health, vision, dental and life insurance, and assumed the risk of financial loss due to medical services that were covered by health plans offered by employers. HNIC did not have "plans"; rather, HNIC issued policies that insured the plans owned by employers.

HNIC received premium payments from self-funded groups and fully-insured companies. HNIC deposited premium checks into its operating account. These premium payments were documented on the company files, records, and ledgers. These premium payments were used to pay salary, rent, leases, bonuses, officer compensation and other expenses of the company. The disposition of these funds by Mr. Frost and Mr. RedCorn formed the basis of the government's criminal prosecution. The criminal charges

alleged unlawful conversion of the general assets of HNIC.

Mr. Frost and Mr. RedCorn were indicted on thirty-one (31) counts of federal financial offenses. Count 1 was Health Care Fraud, Counts 2-5 were wire fraud and Counts 6-31 were money laundering. The indictment was predicated upon the Government's assertion that HNIC was a Health Care Benefit Program ("HCBP") as defined in 24(b) of Title 18. Specifically, the indictment alleged that Mr. Frost and Mr. RedCorn "did knowingly and willfully embezzle, steal, or otherwise convert to the use of a person other than the rightful owner and did intentionally misapply, approximately $1,264,000.00 of the monies, funds, premiums, credits, and other assets of HNIC, a healthcare benefit program as defined in Title 18, U.S.C. § 24(b)." No court had ever held a privately-owned business entity, which does not provide medical services, to be a "Health Care Benefit Program," and all parties agreed this was a case of first impression.

Mr. Frost hired the Oklahoma law firm of Brewster & De Angelis to defend this criminal matter. Mr. Stanley D. Monroe was appointed counsel for Mr. RedCorn. Counsel raised the issue of whether an insurance company could be a HCBP at a pre-trial hearing. The Honorable Judge Cook ultimately held that whether the government could prove the essential elements of § 669 was a matter of evidence and therefore an issue reserved for the fact-finder.

At trial, counsel for Frost and RedCorn, failed to present evidence or argument to the jury that HNIC was not a "plan" or a "contract," and thus, not a HCBP as defined in § 24(b) of Title 18. The jury returned verdicts of guilty on all counts. The Honorable Judge Friot sentenced Mr. Frost and Mr. RedCorn to 72 months incarceration, but allowed them to remain free on bond pending the outcome of their direct appeals.

On appeal, counsel for Frost and RedCorn drafted and planned to file a 16,000 word appellants' brief. Counsel filed an untimely exemption request to the 14,000 word limit, which was denied by the Tenth Circuit. In order to meet the briefing limitation, appellate counsel Robert R. Nigh, a partner in Brewster & DeAngelis, deleted approximately 2,000 words from the brief. Among those 2,000 deleted words were the critical arguments that 1) an insurance company was not a "plan" or "contract" under § 24(b) of Title 18 – rather, HNIC issued policies that insured the plans owned by employers; and 2) no evidence was presented to the jury that HNIC was a HCBP.

On direct appeal, the Tenth Circuit dismissed Counts 2-5 for insufficiency of the evidence. However, the Tenth Circuit denied Mr. Frost's and Mr. RedCorn's challenges to the sufficiency of the evidence on Count 1 by holding that Mr. Frost and Mr. RedCorn waived the issue by virtue of their failure to brief the issue. *United States v. RedCorn*, 528 F.3d 727, 738 n.4 (10th Cir. 2008). Additionally, because the argument in Count 1 was deemed waived, the Tenth Circuit determined the funds were criminally derived, and

therefore, the evidence was sufficient on the money laundering charges. *Id.* at 743. Mr. Frost and Mr. RedCorn petitioned the court to rehear Count 1, attaching to their motion the Affidavit of Robert Nigh, wherein Mr. Nigh admitted that the error was not a strategic decision, but an inadvertent error. The court declined to rehear the issue.

Pursuant to 28 U.S.C. § 2255, Mr. Frost and Mr. RedCorn filed a motion to vacate, set aside or correct a sentence, wherein they sought relief on the basis that they were denied effective assistance of counsel by appellate counsel's failure to brief the sufficiency of the evidence claim as to Count 1, thereby resulting in waiver of the issue. Further, the § 2255 Motion stated that had the issue been properly briefed: (1) Mr. Frost and Mr. RedCorn would have prevailed on direct appeal; (2) the convictions on Counts 1 and 6-31 would have been vacated; and (3) the indictment would have been ordered dismissed. The United States District Court for the Northern District of Oklahoma denied the § 2255 Motion.

The U.S. Court of Appeals for the Tenth Circuit affirmed the decision of the District Court. Turning to the second prong of the test laid out by this Court in *Strickland v. Washington*, 466 U.S. 668, 687, 104 S.Ct. 2052 (1982), the Tenth Circuit held that Mr. Frost and Mr. RedCorn were not prejudiced by appellate counsel's omission of the argument that a privately-held insurance company could not be a "plan" or "contract" under 24(b) of Title 18. *United States v. Frost*, 355 Fed. Appx. 230, 234 (10th Cir.

2009). Specifically, the Tenth Circuit found that a privately-held business entity, which does not provide medical services, can be a health care benefit program under 18 U.S.C. § 24(b). *Id.*

The Court of Appeals denied rehearing *en banc*.

REASONS FOR GRANTING THE PETITION

This is a case of first impression. By denying the § 2255 Motion, the Tenth Circuit has decided an important federal issue in a way which extends 18 U.S.C. § 669 beyond its intended application. The Tenth Circuit found that Mr. Frost and Mr. RedCorn were not prejudiced by appellate counsel's omission of the argument that a privately-owned business-entity engaged in the business of selling insurance contracts was not a "plan" or "contract" under 24(b) of Title 18, because the merits of this argument "would have failed." The Tenth Circuit's holding is based upon the finding that a privately-owned insurance company, specifically the business-entity itself as opposed to merely the policies it sells, may be a health care benefit program under 18 U.S.C. § 24(b).

Prior to the Tenth Circuit's pronouncement regarding the scope of 18 U.S.C. § 669, no other court had reached the conclusion that a privately-held business entity which did not provide medical services fell within the ambit of 18 U.S.C. § 669.

The Court should grant certiorari to address the Tenth Circuit's extension of 18 U.S.C. § 669 to privately-owned, non-medical service provider business entities. The Tenth Circuit's decision has not only resulted in the wrongful incarceration of Mr. Frost and Mr. RedCorn, but also extended application of 18 U.S.C. § 669 to the private insurance industry. The Tenth Circuit's decision encourages prosecutors to bring criminal charges against a privately-owned insurance company's owners and executives based solely upon the prosecutors' disagreement with the owners' or executives' business judgment, including the administration and distribution of company funds.

Consideration by this Court is necessary to resolve an underlying issue of exceptional importance: whether a privately-owned business entity engaged in the business of selling insurance is a HCBP under the provisions of the statute. If the Court finds that such an entity cannot be a HCBP under the statute, then Petitioners request that the Court determine whether appellate counsel's failure to brief the issue on direct appeal constitutes the "prejudicial effect" necessary to satisfy this Court's *Strickland* test for ineffective assistance of counsel.

A. A Privately-Owned Insurance Company Is Not A "Health Care Benefit Program" As Defined In 18 U.S.C. § 24(b).

Title 18 U.S.C. § 669 and Title 18 U.S.C. § 24(b) are part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). *United States v. Whited*, 311 F.3d 259, 264 (3rd Cir. 2002), citing *The Health Insurance Portability and Accountability Act of 1996*, Pub. L. No. 104-191, 110 Stat. 1936. The statute makes clear Congress's intent to criminalize theft or embezzlement under 18 U.S.C. § 669 from a "plan or contract" under which a medical benefit, item, or service is provided, or a medical services provider, to whom payment may be made under a "plan or contract." *See Whited*, 311 F.3d at 264; 18 U.S.C. § 24(b).

Congress set forth different definitions for health plans and insurance companies in HIPAA. *See* 29 U.S.C. § 1191b(b)(2). Nowhere in the provisions of HIPAA are a health care benefit program or plan and an insurance company defined as the same thing. Thus, nowhere in the statute are the inner workings of a privately-owned insurance company considered a "health care benefit program."

House Report No. 104-747, submitted to support the passage of the anti-fraud provisions in HIPAA, detailed the concerns and types of fraud to be addressed. The types enumerated included primarily

false claims for services not provided.[1] (H.R.Rep. No. 104-747 at pp. 7-9). However, House Report No. 104-747 nowhere referenced depletion of assets by insurance company officers, nor did it mention a shareholder/owner's administration of the assets of his or her privately-owned insurance company. *Id.* House Report No. 104-747 indicates that the purpose is to prevent and protect public and private payors from distinct types of criminal activity, i.e. claimant and provider fraud against health care benefit programs. There is no indication that Congress intended to criminalize shareholder's and management's

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[1] Specifically, House Report No. 104-747 discusses the following fraudulent schemes:

(1) Submission of claims for services that are not needed, nor provided, or overpriced;

(2) Kickback schemes for referral services;

(3) Bribing doctors and referral sources to refer patients, improper waiver of Medicare co-payments, billing fraud, and billing for services not rendered and for treatment that was not reasonable or necessary;

(4) Performance of medically unnecessary tests on unsuspecting patients, the so-called "Rolling Labs" case;

(5) Prescription drug fraud;

(6) Submission of false claims;

(7) Staged automobile accidents and related casualty and health insurance fraud; and

(8) Telemarketing health care fraud schemes with deceptive practices in selling medical equipment.

(H.R.Rep. No. 104-747 at pp. 7-9).

disposition of general assets of a privately-owned insurance company that issues policies of indemnity insurance to health care plans. *See id.*

Notwithstanding the legislative history's indication that Petitioners' conduct is not of the type that Congress intended to criminalize, the Government's interpretation and Tenth Circuit's holding blurs the line between lawful and criminal conduct within the context of a business owner's exercise of control over the general assets of his or her privately-owned insurance company. The Tenth Circuit decision makes no attempt to identify the difference between a lawful bonus, distribution, dividend or salary, and a criminal bonus, distribution, dividend or salary. Each of the aforementioned would ostensibly be funded by the general assets of a privately-owned insurance company. However, under the Government's interpretation of 18 U.S.C. §§ 24(b) and 669, and the Tenth Circuit's holding regarding same, the legal dividing line between lawful and criminal activity would be determined only by a prosecutor's zeal and ability to influence the fact-finder. The Tenth Circuit's holding in this case essentially allows federal prosecutors to set their own bar regarding what type of activity constitutes a violation of 18 U.S.C. § 669.

Until the Tenth Circuit's unprecedented expansion of the scope of this criminal statute, cases involving "health care benefit programs" fell in line with the types of fraud addressed in House Report No. 104-747. *See, e.g., United States v. Heavy Runner*, 2002 WL 31133353 (9th Cir. 2002) (defendant was the

assistant administrator of a nursing home, clearly a healthcare facility and healthcare provider); *Smith v. United States*, 2004 WL 2504381 (S.D.N.Y. 2004) (defendant stole checks payable to healthcare providers); *United States v. Francis*, 2003 WL 1701978 (S.D.N.Y. 2003) (same). These cases involved claimant or provider fraud against a health care benefit program.

The authority relied upon by the Tenth Circuit also misses the mark. Although the Tenth Circuit acknowledged no precedent was directly on point, the Tenth Circuit erroneously relies on *Whited* and *Lucien* for the proposition that an insurance company providing insurance for medical payments made pursuant to plans or contracts qualifies as a health care benefit program, itself. *See United States v. Frost*, 355 Fed. Appx. 230 (10th Cir. 2009).

In *United States v. Whited*, 311 F.3d 259 (3d Cir. 2002), Whited, a chiropractic center receptionist, was responsible for receiving payment from the center's patients. *Id.* at 261. It was common practice for the patients to pay the center by endorsing a check from their insurance provider, Blue Cross. *Id.* Whited deposited over fifty of these checks in her personal bank account. *Id.* Whited was charged with embezzling funds from a HCBP under the provisions of 18 U.S.C. § 24(b). *Id.* at 263. The Third Circuit held that the chiropractic center was a local provider of chiropractic services which was compensated pursuant to a plan. *Id.* at 264. Thus, Whited embezzled funds from a "medical services provider," i.e., the

chiropractic center, in violation of the second part of 18 U.S.C. § 24(b) (any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract). Notably, Whited was guilty of embezzling money from a HCBP via 18 U.S.C. § 24(b)'s "medical service provider" prong, not the "plan or contract" prong.

In *United States v. Lucien*, 347 F.3d 45 (2d Cir. 2003), the defendants were convicted for posing as injured passengers in staged automobile collisions designed to exploit state no-fault automobile insurance. *Id.* at 49. The defendants used fictitious medical records to support phony claims for personal injury to obtain a medical benefit from vehicle owners' no-fault insurance contracts. *Id.* at 52. The Second Circuit found that the defendants' conduct fell within the statute because insurers – bound by insurance contracts – reimbursed various medical providers for fraudulently billed medical expenses incurred on behalf of the defendants. *Id.* Thus, the court held that "because [defendants] received a *medical benefit* as a result of the vehicle owner's no-fault *insurance contracts*, a health care benefit program is, under the statutory definition of § 24(b), plainly implicated." *Id.* (emphasis in original). In reaching this conclusion, the Second Circuit noted that House Report No. 104-747 specifically identified "staged automobile accidents and related casualty and health insurance fraud" in a list of "[o]ther examples of health care fraud cases." *Id.* at 51 (quoting H.R.Rep. No. 104-474 at pp. 7-9). Thus, *Lucien* involved fraudulent claims to obtain medical benefits under an insurance contract.

Neither of the cases relied upon by the Tenth Circuit extends the scope of the criminal statute to include a private company which does not provide medical services within the definition of a "health care benefit plan." Neither case addresses disposition of general assets of a private insurance company by its shareholders and management. Neither case addresses whether an insurance company itself is a HCBP.

Under the plain language of the statute, a business entity may only be a "health care benefit program" if the entity provides medical services for which payment may be made under a plan or contract. 18 U.S.C. §§ 24(b) & 669. Otherwise, the statute is limited in scope to theft or embezzlement from a "plan or contract" under which medical benefits, items or services are provided. *Id.*

To the extent any ambiguity exists as to the scope of the statute, the ambiguity should be resolved in favor of Mr. Frost and Mr. RedCorn. As the Court recently noted, "ambiguity concerning the ambit of criminal statutes should be resolved in favor of lenity." *Skilling v. United States*, 561 U.S. ___, No. 08-1394 (June 24, 2010); *see also Rewis v. United States*, 410 U.S. 808, 812 (1971). The rule of narrow construction is rooted in both the concern of the law for individual rights and the belief that fair warning should be accorded as to what conduct is criminal and punishable by deprivation of liberty. *Huddleston v. United States*, 415 U.S. 814, 831, 94 S.Ct. 1262 (1974). Here, the Government's broad construction of the statute is not limited to criminal activity by a

claimant or provider, but extends to the inner workings of a private insurance company and its general assets. There is nothing in the statute or legislative history to indicate that the inner workings of a private insurance company can be considered a "HCBP."

If Congress desired to extend embezzlement liability to officers of a private insurance company for "unlawful taking" of general assets of the company within 18 U.S.C. §§ 24(b) and 669, Congress certainly could have done so. *See McNally v. United States*, 483 U.S. 350, 360, 107 S.Ct. 2875 (1987) ("If Congress desires to go further, it must speak more clearly than it has."). Congress could have included the general assets of a private insurance company within the definition of "health care benefit plan" in 18 U.S.C. § 24(b). Congress also could have included insurance companies within the language of 18 U.S.C. § 669. Congress did not take these actions. The Government's interpretation of § 24(b), as it applies to § 669, criminalizes conduct that Congress had no intent to regulate. Nothing in the statutory language indicates Congress intended to criminalize the inner operations, accounting or compensation of the officers of a private insurance company.

If Congress intended a health care benefit plan to include an entity which provides group indemnity policies, Congress could have defined a "HCBP" as any public or private plan or contract, or entity that provides a plan or contract, under which any medical benefit, item, or service is provided to any individual. Congress knew how to include entities within the

definition of a "HCBP." However, Congress specifically limited the statute's application to entities which provide medical benefits, items, or services for which payment may be made under a plan or contract. *See Franklin Nat'l Bank v. New York*, 347 U.S. 373, 378, 74 S. Ct. 550 (1954) (finding "no indication that Congress intended to make this phase of national banking subject to local restrictions, as it has done by express language in other instances"); *Keene Corp. v. United States*, 508 U.S. 200, 208, 113 S.Ct. 2035 (1993) ("Where Congress includes particular language in one section of a statute but omits it in another . . . , it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion."). An entity is only considered a "HCBP" if: (1) the entity provides medical benefits, items, or services, and (2) payment for those benefits, items, or services may be made under a plan or contract. 18 U.S.C. § 24(b). If the entity does not meet those requirements, the entity is not a "HCBP" under the statute. HNIC does not meet either requirement.

The Tenth Circuit's holding that HNIC, meaning the entity itself, falls within the definition of health care benefit program is erroneous. The statute is not intended to extend to a privately-held business entity that does not provide medical services; nor was it intended to criminalize the inner operations, accounting or compensation of the officers of a privately-held insurance company. HNIC is not a "plan or contract" under which a medical benefit, item, or service is provided to an individual. HNIC is a privately-held

corporation which sold group health insurance, and assumed the risk of loss due to medical services that were covered by health plans offered by employers. The terms "corporation," "plan" and "contract" are not synonymous. Thus, HNIC does not fall under the first prong of the "HCBP" definition. Further, HNIC does not provide medical benefits, items, or services. Because the statute limits the definition of "HCBP" to entities which provide medical benefits, HNIC does not fall under the second prong of the "HCBP" definition.

Further, as Justice Stevens has noted, "we do the country a disservice when we needlessly ignore persuasive evidence of Congress' actual purpose . . . " *W. Va. Univ. Hosps., Inc. v. Casey*, 499 U.S. 83, 115 (1991) (Stevens, J., dissenting). Here, Congress specifically enumerated the evils it sought to derail in House Report No. 104-747. *See supra*, n.1. Absent from the enumeration is disposition of general assets of a privately-owned business entity that, as part of its business activities, issues policies of indemnity insurance to health care plans.

The Government's interpretation also conflicts with a Third Circuit opinion concerning the status of insurance company assets. In *Mack Boring & Parts v. Meeker Sharkey Moffitt*, 930 F.2d 267 (3d Cir. 1991), the Third Circuit held that funds placed in an insurance company's general account, received as premium payments by an employer, do not constitute plan assets. The Third Circuit stated that "[i]f an insurance company issues a contract or policy of insurance to a plan and places the consideration for

such contract or policy in its general asset account, the assets in such account shall not be considered to be plan assets." *Id.* at 276 (quoting Department of Labor Interpretive Bulletin 75-2(b) (IB 75-2)). Thus, insurance company general account assets are not plan assets. Likewise, the general assets of HNIC, a privately-owned insurance company, are not plan assets or contracts under the definition of "health care benefit program."

B. Appellate Counsel's Omission Of Argument That A Private Insurance Company Is Not A "Health Care Benefit Program" As Defined In 18 U.S.C. § 24(b) Constitutes Ineffective Assistance of Counsel.

The Sixth Amendment guarantees a defendant charged with a felony offense "effective" assistance of counsel. *Strickland v. Washington*, 466 U.S. 668, 686, 104 S.Ct. 2052, 2063 (1984). In *Strickland*, the Court articulated a two-part standard for evaluating a defendant's Sixth Amendment claim that he did not receive effective assistance of counsel. *Strickland*, 466 U.S. at 687. In order to prevail on a claim of ineffective assistance of counsel, a defendant must show (1) the defendant did not receive reasonably competent assistance, and (2) that but for the deficient performance of counsel, there is a reasonable probability that the result of the proceeding would have been different. *Id.* In determining whether counsel was ineffective, a court may address either prong of the *Strickland* analysis. *Id.* at 697.

The right to effective assistance of counsel extends not only to trial counsel, but also to a defendant's "first appeal as of right." *Evitts v. Lucey*, 469 U.S. 387, 396, 105 S.Ct. 830, 836 (1985). Appellate counsel's failure to raise a particular claim can form the basis of a *Strickland* ineffective assistance of counsel claim. *See Smith v. Robbins*, 528 U.S. 259, 288, 120 S.Ct. 746 (2000) ("[T]he proper standard for evaluating . . . claim that appellate counsel was ineffective . . . is that in *Strickland* . . . "); *Banks v. Reynolds*, 54 F.3d 1508, 1515-16 (10th Cir. 1995) (finding both prongs of *Strickland* satisfied where appellate counsel failed to raise claim of violation of *Brady v. Maryland*, 373 U.S. 83, 83 S.Ct. 1194 (1963)); *Gray v. Greer*, 800 F.2d 644, 646 (7th Cir. 1986) (stating that "only when ignored issues are clearly stronger than those presented, will the presumption of effective assistance of counsel be overcome.").

In this case, the Tenth Circuit focused solely on the second prong of the *Strickland* analysis. *United States v. RedCorn*, 355 Fed. Appx. 230, 233 (10th Cir. 2009). The Court determined that Mr. Frost and Mr. RedCorn were not denied effective assistance of counsel because "the merits of defendants' insufficiency of the evidence as to Count One claim would have failed." *Id.* at 234. Thus, the Tenth Circuit took the position that Mr. Frost and Mr. RedCorn were not prejudiced by counsel's failure to brief the issue. *Id.*

Initially, it is important to note that the omission of a meritorious defense resulted in a waiver of the

issue on the direct appeal. The Tenth Circuit stated as follows:

> In their brief, the title of the section concerning sufficiency of the evidence appears to announce a challenge concerning Count 1, health care fraud, as well. As the government correctly points out, however, the brief turns out to contain no such argument. We will therefore not consider whether the evidence was sufficient to support that count.

United States v. RedCorn, 528 F.3d 727, 738 at n.4 (10th Cir. 2008). Turning to the Money Laundering Counts (Counts 6-31), the Tenth Circuit stated: "Our review shows that all the transactions charged under § 1957(a) involved the proceeds of the health care fraud charged in Count 1. As we uphold the convictions on that count, the money laundering counts stand as well." *Id.* at 743. Thus, appellate counsel's omission constituted a waiver of the issue, and resulted in the Tenth Circuit upholding the convictions on direct appeal.

As addressed in greater detail in Section A, *supra*, a private insurance company is not a "HCBP" under 18 U.S.C. § 669. Because HNIC does not meet the statutory definition, the government failed to meet its burden of establishing beyond a reasonable doubt all elements of Count One. On direct appeal, Mr. Frost and Mr. RedCorn did not have an opportunity to raise this argument due to counsel's omission. But for the deficient performance of appellate counsel, there is a reasonable probability that

the result of the direct appeal would have been different.

Although not addressed by the Tenth Circuit, there is little doubt that appellate counsel's omission of this argument amounted to deficient performance by counsel. This is not a situation where appellate counsel selected between several non-frivolous issues in order to maximize the likelihood of success on appeal. Rather, it is uncontroverted that the omission of this issue was an inadvertent oversight and not a strategic decision. Appellate counsel intended to address the issue in the context of insufficiency of the evidence, but inadvertently omitted Mr. Frost's and Mr. RedCorn's meritorious defense from the opening brief through an editing error.[2] The omission of a meritorious issue on direct appeal through an editing error certainly does not constitute effective assistance of appellate counsel under the Sixth Amendment.

In short, Mr. Frost and Mr. RedCorn were denied effective assistance of counsel during their direct appeal by the complete omission of the meritorious

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[2] The Affidavit of Robert Nigh states as follows:

> As a result of this oversight Appellants began the discussion of sufficiency of the evidence with reference to the wire fraud counts, and did not make a specific argument concerning Count One. This omission was inadvertent and was not a strategic decision because I believed this to be the strongest claim which had a reasonable chance of success.

Appx. 36-37.

and dispositive argument that Count 1 and Counts 6-31 were unsupported by sufficient evidence. The Tenth Circuit erred in denying the relief sought in the Section 2255 Motion to Vacate.

CONCLUSION

For the reasons set forth above, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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UNITED STATES COURT OF APPEALS
TENTH CIRCUIT

UNITED STATES OF AMERICA, Plaintiff-Appellee, v. BRADLEY N. FROST, and WAKON I. REDCORN, JR., Defendants-Appellants.	Nos. 09-5034, 09-5035 (D. Ct. Nos. 4:05-CR-00001-SPF-2, 4:08-CV-00620-SPF-TLW and 4:05-CR-00001-SPF-1, 4:08-CV-00636-SPF-FHM) (N.D. Okla.)

ORDER AND JUDGMENT*

(Filed Dec. 9, 2009)

Before **TACHA** and **GORSUCH**, Circuit Judges, and **STAMP**, Senior District Judge.**

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* This order and judgment is not binding precedent except under the doctrines of law of the case, res judicata, and collateral estoppel. It may be cited, however, for its persuasive value consistent with Fed. R. App. P. 32.1 and 10th Cir. R. 32.1.

** The Honorable Frederick P. Stamp, Jr., Senior United States District Judge for the Northern District of West Virginia sitting by designation.

Defendants-appellants Bradley N. Frost and Wakon I. Redcorn, Jr., were the president and chief financial officer of Heritage National Insurance Company ("HNIC"), a privately-owned insurance company providing coverage to companies in Oklahoma and Texas. They were indicted in federal district court on charges of embezzlement and misapplication from a health care benefit program and money laundering. A jury found the defendants guilty on all counts, and each was sentenced to concurrent terms of 72 months of imprisonment on every count. The defendants have now filed individual motions to vacate pursuant to 28 U.S.C. § 2255, arguing ineffective assistance of counsel on direct appeal when counsel failed to properly brief an issue. The district court denied each of the defendants' § 2255 motions. We take jurisdiction under 28 U.S.C. §§ 1291 and 2253(a) and AFFIRM.

I. BACKGROUND

The underlying facts of this case are well known to this Court. *See United States v. Redcorn*, 528 F.3d 727 (10th Cir. 2008). HNIC provided life, accident, and group health insurance coverage to fully-insured companies and the individual members thereof. Investor Steven Silverstein and his wife owned half of the company, while Mr. Frost owned the other half. Two "third party administrators" were affiliated with HNIC, which contracted with HNIC to handle the processing of premiums and claims for HNIC's various fully-insured group health insurance plans.

At all relevant times, Mr. Silverstein served as the chairman and Chief Executive Officer of all three affiliated companies. Mr. Frost was the president, and Mr. Redcorn acted as the secretary/treasurer and Chief Financial Officer.

The money that funded the operations of HNIC came from premium payments made by fully-insured groups and individuals having health care benefit insurance contracts with HNIC. The groups insured paid HNIC a premium, and HNIC, under its insurance policies, then provided financial reimbursement for medical services to either the insured employee or the medical provider of the benefit. Thus, the majority of payments made by HNIC were paid directly to health care providers who provided medical services to HNIC policyholders.

Beginning in early 2000, Mr. Frost and Mr. Redcorn began removing money from HNIC for their own benefit. Each took approximately $500,000.00 from HNIC's incoming premium funds in April 2001. Mr. Frost took an additional $233,000.00 and Mr. Redcorn exacted an additional $405,000.00 from the bank accounts of HNIC and the third party administrators. Following an investigation by the Oklahoma Insurance Commission from which this information emerged, Mr. Frost and Mr. Redcorn were indicted on one count of health care fraud for taking money from a health insurance company in violation of 18 U.S.C. § 669, four counts of wire fraud in violation of 18 U.S.C. § 1343, and twenty-six

counts of money laundering in violation of 18 U.S.C. § 1957(a).

The jury returned a verdict of guilty on all counts on December 16, 2005. Mr. Frost and Mr. Redcorn filed a timely appeal, raising four areas for argument: that the indictment was legally insufficient; that the evidence presented at trial was insufficient; that the defendants were entitled to a new trial because of newly discovered evidence; and that the defendants' sentences violated the Constitution. This Court denied the defendants' arguments regarding the indictment, newly discovered evidence, and their sentences. Regarding Mr. Frost's and Mr. Redcorn's insufficiency of the evidence claim, however, this Court denied this argument as to Count One, health care fraud, because the defendants failed to adequately address it in their opening appellate brief. In cutting down the brief, counsel for the defendants apparently, and mistakenly, deleted this argument. Because the argument concerning Count One was deemed waived, this Court consequently determined that the evidence was sufficient on the money laundering charges.[1]

Mr. Frost and Mr. Redcorn filed motions to vacate pursuant to 28 U.S.C. § 2255, alleging ineffective assistance of counsel on appeal. They argue that had

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[1] The Court agreed with the defendants regarding the sufficiency of the evidence on the wire fraud counts and reversed the judgments of convictions as to these counts.

the insufficiency of the evidence claim been properly briefed as to Count One, they would have prevailed on direct appeal. The district court denied the § 2255 motions. The defendants filed timely motions for certificates of appealability, which the district court granted. Mr. Frost and Mr. Redcorn now appeal the denial of their § 2255 motions.

II. DISCUSSION

On appeal, Mr. Frost and Mr. Redcorn argue that the district court erroneously determined that counsel was not deficient. Specifically, they argue that the evidence at trial was insufficient to establish that HNIC was a "health care benefit program" pursuant to 18 U.S.C. § 24(b), as alleged in Count One of the indictment, and that they received ineffective assistance of counsel by the omission of this allegedly meritorious claim.

"We review the district court's legal rulings on a § 2255 motion de novo and its findings of fact for clear error." *United States v. Orange*, 447 F.3d 792, 796 (10th Cir. 2006). "A claim for ineffective assistance of counsel presents a mixed question of fact and law, which we review de novo." *Id.*

To establish a successive [sic] claim for ineffective assistance of counsel, two elements must be met: (1) counsel's performance was deficient; and (2) this deficient performance prejudiced the defendants' defense. *Strickland v. Washington*, 466 U.S. 668, 687 (1984). This Court can choose to first address either prong of

the *Strickland* analysis. *See Strickland*, 466 U.S. at 697 ("The performance component need not be addressed first. If it is easier to dispose of an effectiveness claim on the ground of lack of sufficient prejudice, which we expect will often be so, that course should be followed.") (internal quotations omitted); *Romano v. Gibson*, 239 F.3d 1156, 1181 (10th Cir. 2001) ("This Court can affirm the denial of habeas relief on whichever *Strickland* prong is easier to resolve.").

To establish prejudice, the defendants must show that "there is a reasonable probability that, but for counsel's unprofessional errors, the result of the proceeding would have been different." *Strickland,* 466 U.S. at 693. "When, as here, the basis for the ineffective assistance claim is the failure to raise an issue, we must look to the merits of the omitted issue." *Orange*, 447 F.3d at 797. Counsel's failure to raise an omitted issue that is without merit is not prejudicial, and therefore, is not ineffective assistance. *Id.* Assuming, without deciding, that defendants' appellate counsel was deficient, Mr. Frost and Mr. Redcorn cannot establish prejudice because their argument that HNIC is not a "health care benefit program" under the applicable statute fails on the merits.

Thus, we turn to the merits of the defendant's insufficiency of the evidence argument. This Court reviews claims of insufficient evidence de novo. *United States v. Banks*, 451 F.3d 721, 725 (10th Cir. 2006). "[W]e ask only whether taking the evidence –

both direct and circumstantial, together with the reasonable inferences to be drawn therefrom – in light most favorable to the government, a reasonable jury could find the defendant guilty beyond a reasonable doubt." *Id.* at 725-26 (citing *United States v. Radcliff*, 331 F.3d 1153, 1157 (10th Cir. 2003)).

Count One of the indictment charges the defendants with embezzlement in connection with health care and aiding and abetting in violation of 18 U.S.C. § 669. This statute forbids embezzlement of "the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program." "Health care benefit program" is defined as follows:

> [T]he term "health care benefit program" means any public or private plan or contract, affecting commerce under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.

18 U.S.C. § 24(b). Mr. Frost and Mr. Redcorn argue that there was insufficient evidence to support the conclusion that HNIC fits within the statutory definition of health care benefit program. HNIC is an insurance company, they argue, and therefore it cannot be a "plan or contract" under 18 U.S.C. § 24(b).

"[I]t is our primary task in interpreting statutes to determine congressional intent, using traditional tools of statutory construction. In ascertaining such congressional intent, we begin by examining the statute's plain language, and if the statutory language is clear, our analysis ordinarily ends." *Coffey v. Freeport McMoran Copper & Gold*, 581 F.3d 1240, 1245 (10th Cir. 2009) (citing *Russell v. United States*, 551 F.3d 1174, 1178 (10th Cir. 2008)). If the language of the statute is clear and unambiguous, the plain language of the statute controls. *United States v. Quarrell*, 310 F.3d 664, 669 (10th Cir. 2002). The defendants' argument that HNIC is not a health care program is undermined by the clear statutory language.

HNIC is a private insurance company that makes payments to providers for the cost of medical services. Although producing no precedents that are directly on point, our sister circuits have held that an insurance company that provides such medical payments qualifies as a health care benefit program. *See United States v. Whited*, 311 F.3d 259 (3d Cir. 2002) ("The [medical] Center is a local provider of chiropractic services and even [the defendant] concedes that payment is made for those services through Blue Cross, which is undisputably a health care benefit program."); *United States v. Lucien*, 347 F.3d 45 (2d Cir. 2003) ("[P]rivate insurers – bound by insurance contracts purchased by vehicle owners . . . – reimbursed various medical providers for fraudulently billed medical expenses . . . Because [the defendants]

received *a medical benefit* as a result of the vehicle owners' no fault *insurance contracts*, a health care benefit program is, under the statutory definition of § 24(b) plainly implicated.") (emphasis included).

The defendants argue that these cases are inapposite and that HNIC is not a health care benefit program because it is not a "plan or contract." The district court, in denying the defendants' § 2255 motions, found that HNIC held health care benefit insurance contracts with its fully-insured groups:

> There was evidence that money which funded the operations and claims payments by the third-party administrators which were affiliated with HNIC and which had contracts with HNIC, as well the money that funded HNIC, came from premium payments from fully-insured groups which had health care benefit insurance contracts with HNIC.

(Or. Denying § 2255 at 9, Mar. 4, 2009.) At oral argument, counsel did not dispute this finding, and in fact, conceded that this finding was both true and correct. Thus, in that HNIC held these contracts with participating companies, and thereafter made payments to medical providers for medical services actually provided to the individuals of these companies, 18 U.S.C. § 24(b) precisely encompasses such activity.

Finally, a panel of this Court has previously held, in dicta, that a private insurance company that pays providers for the cost of medical services is the

private equivalent of Medicare or Medicaid, which it stated are undisputably health care programs under § 24(b). *See Redcorn*, 528 F.3d at 734. This Court is not bound by a prior panel's dicta. *Bates v. Dep't of Corr.*, 81 F.3d 1008, 1011 (10th Cir. 1996). Nevertheless, this Court finds this dicta highly persuasive in deciding the issue currently before it. Several courts have held that the Medicare and Medicaid programs are both health care benefit programs as defined in 18 U.S.C. § 24(b). *See e.g. United States v. McGovern*, 329 F.3d 247, 248-49 (5th Cir. 2003) (collecting cases); *United States v. Martinez*, 2009 WL 4251064 (6th Cir. Dec. 1, 2009) (unpublished). HNIC, similar to Medicare and Medicaid, provides health insurance to individuals. As such, HNIC, too, is a health care benefit program. Accordingly, the defendants' insufficiency of the evidence argument as to Count One must fail on its merits. Because the evidence is sufficient to support Count One of the conviction, the convictions on the money laundering counts must be upheld, as well.

As herein discussed, the merits of the defendants' insufficiency of the evidence as to Count One claim would have failed. No prejudice from counsel's failure to brief this issue therefore occurred. Consequently, the defendants have not satisfied the prejudice prong of *Strickland*, and the district court appropriately denied their § 2255 motions based on ineffective assistance of counsel.

III. CONCLUSION

The district court did not err in denying the defendants' § 2255 motions. We therefore AFFIRM.

ENTERED FOR THE COURT,

Frederick P. Stamp, Jr.
Senior District Judge

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

UNITED STATES OF AMERICA,	)	
Plaintiff,	)	Case No. 5-CR-001-SPF
	)	(Civil Action No.
vs.	)	08-CV-620, Frost)
WAKON IRON REDCORN, JR., and BRADLEY N. FROST,	)	(Civil Action No. 08-CV-636, Redcorn)
Defendants.	)	

ORDER

Bradley N. Frost and Wakon I. Redcorn, Jr., have each moved to vacate judgment and sentence and for discharge of the defendant pursuant to 28 U.S.C. §2255. (Frost's § 2255 motion to vacate at doc. no. 187; Redcorn's § 2255 motion to vacate at doc. no. 191.) Mr. Frost and Mr. Redcorn have also each moved for an evidentiary hearing on their respective § 2255 motions. (Frost's motion for hearing at doc. no. 189; Redcorn's motion for hearing at doc. no. 193). Mr. Redcorn has also moved for appointment of counsel. (Doc. no. 209.) The briefing is complete. Mr. Redcorn appears *pro se,* and his pleadings are liberally construed.

Summary of § 2255 Arguments

In support of their motions to vacate under § 2255, movants argue that they were denied effective assistance of appellate counsel in violation of the Sixth Amendment to the United States Constitution. Specifically, movants argue that in their briefs in support of their direct appeal to the Tenth Circuit, movants' appellate counsel inadvertently deleted an argument which movants contend would have resulted in a reversal of movants' convictions on all counts as to which they remain convicted.[1]

The deleted argument contended that the evidence was insufficient to convict the defendants on count one. Count one charged violation of 18 U.S.C. §669. Section 669 makes it a crime to embezzle or steal funds or other assets of a "health care benefit program" as that term is defined in 18 U.S.C. § 24(b).[2] Section 24(b) provides that the term "health care benefit program" "means any public or private plan or

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[1] The direct appeal resulted in a reversal of movants' convictions on wire fraud charged in counts two through five. *United States v. Redcorn and Frost*, 528 F.3d 727, 742 (10th Cir. 2008).

[2] Title 18 U.S.C. § 669(a) provides that "Whoever knowingly and willfully embezzles, steals, or otherwise without authority converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program," commits a crime. Section 669(b) provides that "As used in this section, the term 'health care benefit program' has the meaning given such term in §24(b) of this title."

contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract." The deleted argument contended that the evidence did not show that the funds movants were convicted of embezzling were the funds of a health care benefit program. The deleted argument contended that the evidence showed that Heritage National Insurance Company (HNIC) – the entity whose funds defendants were convicted of embezzling – was an insurance company rather than a plan or contract within the § 24(b) statutory definition of a health care benefit program.

The second part of movants' argument in support of their § 2255 motion is that because there is insufficient evidence to support movants' convictions on count one, the evidence is also insufficient to support movants' convictions on the money laundering counts.[3] The money laundering counts charge a violation of 18 U.S.C. § 1957(a). That statute punishes anyone who "knowingly engages or attempts to engage in a monetary transaction in criminally derived property of a value greater than $10,000 and is derived from specified unlawful activity." Movants

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[3] Counts 6 through 23 are the money laundering counts on which Mr. Redcorn was convicted, and counts 24 through 31 are the money laundering counts on which Mr. Frost was convicted, all in violation of 18 U.S.C. § 1957(a).)

argue that because there is insufficient evidence to support their conviction for embezzling funds from a health care benefit program, there is no evidence that movants engaged in monetary transactions involving criminally derived property.

Thus, movants contend that the failure of their appellate counsel to raise the count one argument deprived movants of a meritorious argument on appeal not only with respect to count one but also with respect to the money laundering counts, so that movants are now entitled to relief under §2255 with respect to all charges of which they remain convicted.

Standards

The criteria for determining an ineffective assistance of counsel claim are stated in *Strickland v. Washington,* 466 U.S. 668 (1984).[4] To be successful, a claimant alleging ineffective assistance of counsel must establish the existence of two criteria: deficient

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[4] *Strickland* was a habeas case involving a collateral attack in federal court on a state court conviction. In *Strickland,* petitioner was convicted of murder and was sentenced to death. Among other arguments, petitioner argued that his counsel had been ineffective at the sentencing proceeding. *Strickland,* 466 U.S. at 675, 678. Unlike the instant matter, *Strickland* did not involve a claim of ineffective assistance of counsel during appellate proceedings. The Tenth Circuit, however, applies the standards of *Strickland* in assessing the effectiveness of appellate counsel in the context of § 2255 proceedings. *United States v. Cook,* 45 F.3d 388, 392 (10th Cir. 1995).

performance by counsel and prejudice to the claimant's defense as a result of that deficient performance. *Id.* at 687. Defendants asserting ineffective assistance of counsel have the burden of showing prejudice. *Id.* at 693. To carry that burden, defendants must show there is a reasonable probability that but for counsel's unprofessional errors, the result of the proceeding would have been different. *Id.* at 694. A reasonable probability is a probability sufficient to undermine confidence in the outcome. *Id.*

A failure by a defendant to carry his burden with respect to either criterion – proof of deficient performance or proof of resulting prejudice – is dispositive of the ineffective assistance of counsel claim. *United States v. Orange,* 447 F.3d 792, 796-97 (10th Cir. 2006). Accordingly, the court may resolve the issue of ineffective assistance of counsel based on whichever criterion is easier to decide. *Romano v. Gibson,* 239 F.3d 1156, 1181 (10th Cir. 2001).

When a defendant alleges that his appellate counsel rendered ineffective assistance by failing to raise an issue on appeal, the court examines the merits of the omitted issue. *See, id.* ("When a defendant alleges his appellate counsel rendered ineffective assistance by failing to raise an issue on appeal, we examine the merits of the omitted issue."). Obviously, if the deleted argument was not meritorious then its omission did not prejudice the defendant on direct appeal. As stated in *Carole v. Mullein,* 317 F.3d 1196, 1205 (10th Cir. 2003), "The very focus of a *Strickland*

inquiry regarding performance of appellate counsel is upon the merits of the omitted issues. . . ."

Section 669 Convictions

Movants present affidavits from the attorneys involved in the events in question to show that their "insufficiency of the evidence to support count one argument" was inadvertently deleted from their moving brief on appeal. For purposes of this motion, the court assumes the truth of the factual contentions contained in those affidavits. The conclusions reached in this order, however, make the truth of those facts immaterial because, as it is allowed to do under the above-quoted standards, this court considers only whether the omission was prejudicial and not whether the omission qualifies as deficient performance.

As stated above in the "standards" portion of this order, in order to determine whether prejudice resulted from the inadvertently deleted argument in the direct appeal, the court considers the merits of the deleted argument. In the circumstances of these proceedings, this court considers the merits of the deleted argument *de novo*.[5]

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[5] The government argues that the law of the case doctrine governs this court's review. Although this court and the Tenth Circuit have previously ruled on issues that underlie movants' ineffective assistance of counsel claim, this court has not previously considered the merits of movants' position on these issues as part of an ineffective assistance of counsel claim. The

(Continued on following page)

Despite conducting *de novo* review, it is appropriate to note, for purposes of context only, previous rulings at the district court level which have related to the merits of the deleted argument.

The undersigned has denied successive motions for judgment of acquittal on all counts including count one. The deleted argument was presented in support of those denied motions.

Furthermore, before this case was transferred to the undersigned, it was assigned to Judge H. Dale Cook. Judge Cook denied motions to dismiss count one brought by both defendants in the underlying criminal matter. In doing so, Judge Cook stated that the legislative history of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) of which § 669 is a part, "indicates that the act was passed to close loopholes in current mail and wire fraud statutes to include criminal penalties for serious and egregious violations of fraud and abuse on the health care industry." (Doc. no. 37, p. 3, citing 142 Cong. Rec. S6116-01, *S6116.) This statement was part of Judge Cook's reasoning for rejecting defendants' arguments presented in their motions to dismiss, which included the argument that count one

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court is skeptical about the government's view that it is bound by law of the case. Regardless, the court prefers to give movants the benefit of the most liberal standard of review that is arguably applicable. Accordingly, the court reviews the issues raised in this § 2255 proceeding *de novo*, giving no deference to the law of the case doctrine.

should be dismissed because HNIC was not a health care benefit program within the meaning of § 669 and § 24(b).

It is also necessary to review any statements in *United States v. Redcorn and Frost,* 528 F.3d 727 (10th Cir. 2008) that might bear on the merits of the deleted argument. In the direct appeal, the Tenth Circuit found that count one of the indictment adequately charged defendants with embezzlement of a health care benefit program in violation of § 669. In that discussion, the Court of Appeals noted defendants' argument that it was not possible for a private insurance company to be a health care benefit program as defined in the Act because such a company was not a plan or contract.

The Court of Appeals stated it was "not necessarily persuaded" by defendants' argument. *Redcorn and Frost,* 528 F.3d at 734. The Court of Appeals explained as follows: "A private insurance company, which makes payments to providers for the cost of medical services, appears to be the private equivalent of Medicare or Medicaid. These are unquestionably health care programs under §24(b)." *Id.* at 734 (citations omitted). The Court of Appeals, however, immediately went on to note: "But there are no precedents squarely on point, and this seems to be an open question. We need not answer it here. Whether HNIC actually was an insurance company is a matter of the evidence, not the indictment, and if it was not, then the issue is moot." *Id.* While this excerpt makes clear that the Tenth Circuit has not revealed any definitive

view on whether it is possible for a private insurance company such as HNIC to be a health care benefit program for purposes of a prosecution for violation of 18 U.S.C. § 669, the passage may be read as expressing at least tentative skepticism about the merits of movants' contention that a company such as HNIC cannot be both a private insurance company and a health care benefit program within the meaning of § 669 and § 24(b). Messrs. Redcorn's and Frost's motions for supplemental briefing on the deleted argument, and their motions for rehearing *en banc,* were denied by the Court of Appeals.

Regardless of how much or little weight, if any, is given to these developments in the direct appeal, it is a fair conclusion that the *Redcorn and Frost* decision does not provide Redcorn and Frost with much comfort as to the merits of the deleted argument. There is nothing in that decision to suggest, paraphrasing *Strickland,* that but for counsel's errors the result would have been different on appeal; nor is there anything in that decision to suggest that confidence in the convictions has been undermined.

With this background in mind, this court now considers the merits of movants' deleted argument *de novo.*

Movants are correct that the evidence is undisputed that HNIC was a private insurance company. As a legal matter, however, the court rejects movants' position that this fact means HNIC cannot also be a health care benefit program for purposes of this

prosecution. Movants' position is primarily based on the contention that a private insurance company is not a plan or contract as required by the portion of the §24(b) definition of health care benefit program relied on by the government. This court agrees with the observation made in *Redcorn and Frost,* however, that "a private insurance company, which makes payments to providers for the cost of medical services, appears to be the private equivalent of Medicare or Medicaid . . . [which] are unquestionably health care programs under §24(b)." *Id.*

Authorities from other circuits also support the government's interpretation of § 24(b) as inclusive of entities such as HNIC. *See, e.g., United States v. Lucien,* 347 F.3d 45, 52 (2d Cir. 2003) (appeal of defendants' conviction under 18 U.S.C. § 1347, health care fraud statute which criminalizes defrauding a health care benefit program; defendants' argument that "New York State no-fault automobile insurance program is not a health care benefit program within the meaning of the statute" described as "wholly without merit"; because defendants received a medical benefit "as a result of the vehicle owners' no-fault *insurance contracts,* a health care benefit program is, under the statutory definition of § 24(b), plainly implicated," emphasis in original). *And see, United States v. Whited,* 311 F.3d 259, 264 (3d Cir. 2002) (appeal of defendant's conviction under § 669; indictment described misapplication of checks "from Blue Cross of Northern Pennsylvania, a health care benefit program within the meaning of 18 United States

Code 24(b), which checks rightfully belonged to the Back Mountain Chiropractic Center"; court noted even defendant conceded "payment is made for those services through Blue Cross, which is undisputably a health care benefit program"; court went on to hold that the indictment was sufficient, that the chiropractic center was a qualifying health care benefit program within the meaning of § 669; court described purpose of the Act as "an extensive attack on frauds against the health care industry").

This court concludes that, as a legal proposition, insurance companies may, in certain circumstances, constitute health care benefit programs within the definition of § 24(b) for purposes of 18 U.S.C. § 669 regarding theft or embezzlement in connection with health care.

The court now evaluates the evidence in this particular case to determine whether it, in fact, brings HNIC, an insurance company, within the § 24(b) definition of a health care benefit program for purposes of this prosecution under § 669. Specifically, the court reviews the record to determine whether there is evidence to show that HNIC, as a private insurance company, was a private plan or contract, affecting commerce, under which any medical benefit or service was provided to any individual.

Having conducted that review, the court finds the record includes the following evidence.

There was evidence that at all times material to count one, HNIC was an insurance company whose

principal business was providing group health care insurance coverage for companies in Oklahoma and Texas. (Tr. p. 415.)

There was evidence that HNIC made payments to providers for the cost of medical services. There was testimony that the majority of checks that came out of HNIC went to "medical providers, doctors, and things like that." (Tr. p. 1530.)

There was evidence that money which funded the operations and claims payments by the third-party administrators which were affiliated with HNIC and which had contracts with HNIC, as well the money that funded HNIC, came from premium payments from fully-insured groups which had health care benefit insurance contracts with HNIC. (Tr. pp 159-169.)

There was evidence that the insurance HNIC provided to these fully-insured groups included medical insurance, dental insurance, vision insurance, and life insurance. (Tr. p. 163.)

There was evidence that about eighty percent of HNIC's business was attributed to providing health care insurance coverage. (Tr. p. 163.)

More generally with respect to count one, there was ample evidence that Messrs. Redcorn and Frost took and misapplied, for their personal gain, substantial amounts of HNIC's finds [sic] – amounts far in excess of their salaries. (Tr. *passim*.)

This is evidence from which the jury could have concluded that HNIC was a plan or contract that made payments to providers for the cost of medical services provided to individuals. Accordingly, the court finds that there is sufficient record evidence to support the conclusion that HNIC comes within the statutory definition of a health care benefit program for purposes of this prosecution.

In reaching this conclusion, this court readily acknowledges, as it has before, that an insurance company such as HNIC, which was contracting with third-party administrators and receiving premium payments from fully-insured groups, does not necessarily come within the core coverage of § 669. This court also readily acknowledges that each time the issue of HNIC's fit within the statutory definition of § 24(b) has come before it, the undersigned has found the issue to be something of a close call. Having considered the issue yet again in the context of these § 2255 proceedings, the court's impression regarding this issue is no different now. Nevertheless, the court concludes that the evidence in this case brings HNIC within the four corners of the statutory definition of a health care benefit program as that term is defined in §24(b) for purposes of Messrs. Redcorn's and Frost's convictions for violation of 18 U.S.C. § 669 regarding theft or embezzlement in connection with health care.

As there is sufficient evidence to support the jury's finding that HNIC was a health care benefit program within the meaning of count one, movants have not met their high burden of showing that no

rational trier of fact could have found Messrs. Redcorn or Frost guilty beyond a reasonable doubt. *See, Boyle v. McKune*, 544 F.3d 1132, 1140-41 (10th Cir. 2008) (petitioner in § 2254 proceeding argued his state appellate counsel provided ineffective assistance by failing to raise issue of sufficiency of the evidence on direct appeal, arguing that his state appellate counsel should have challenged a particular witness's credibility on appeal; the Court of Appeals stated that to prevail on a sufficiency of the evidence claim a defendant must meet "the high burden" of showing on the record evidence that no rational trier of fact could have found proof of guilt beyond a reasonable doubt; the Court of Appeals stated that the credibility argument would have been "a sure loser on appeal" and found no error in the district court's denial of habeas relief). Movants have not shown a reasonable probability of success based on the argument that was inadvertently deleted from their appeal brief. This means that movants were not denied effective assistance of counsel on appeal with respect to their count one argument. The motions for § 2255 relief with respect to count one will be denied.

Money Laundering Convictions

Movants' § 2255 argument with respect to the insufficiency of the evidence to support their convictions on the money laundering charges depend on the success of their argument regarding the insufficiency of the evidence to support the count one convictions. The court's conclusion that the evidence is sufficient

to support the count one convictions thus compels the conclusion that movants' § 2255 arguments with respect to the money laundering counts are not meritorious. There is ample evidence showing that criminally derived property was the subject of the movants' monetary transactions.

Conclusion Regarding § 2255 Relief

For the reasons stated above, the record conclusively shows movants are not entitled to § 2255 relief on any counts.

Evidentiary Hearing

The court next addresses movants' request for an evidentiary hearing. The Tenth Circuit has held that a hearing on a claim of ineffective assistance of counsel in a §2255 matter is not required where the district court finds that the record conclusively shows the prisoner is entitled to no relief. *United States v. Marr,* 856 F.2d 1471, 1472 (10th Cir. 1988); *United States v. Evans,* 51 F.3d 287, *1 (10th Cir. 1995) ("Because defendant is not entitled to 2255 relief, the district court did not err in failing to hold an evidentiary hearing," unpublished decision cited here per the requirements of Tenth Circuit Rule 32.1). Having found that the record conclusively shows movants are not entitled to § 2255 relief, the court further finds that neither movant has shown that he is entitled to an evidentiary hearing. Accordingly, the motions for an evidentiary hearing will be denied.

Appointment of Counsel

Lastly, the court takes up Mr. Redcorn motion for appointment of counsel. When relief is denied without an evidentiary hearing, there is no constitutional right to appointment of counsel in a § 2255 proceeding and no statutory right to counsel under Rule 8(c) governing § 2255 proceedings. *See, Swazo v. Wyoming Department of Corrections State Penitentiary Warden,* 23 F.3d 332, 333-34 (10th Cir. 1994) (to the extent there is no constitutional right to counsel beyond the appeal of a criminal conviction, generally appointment of counsel in a § 2254 proceeding is left to the court's discretion; rules governing § 2255 cases are the same; and quoting *United States v. Vasquez,* 7 F.3d 81, 84 (5th Cir. 1993) for rule that "Until the judge decides to hold a hearing, he has discretion over whether to appoint counsel. However, if an evidentiary hearing is held, the judge *shall* appoint counsel."). Here, no evidentiary hearing is required. Additionally, Mr. Redcorn has presented very competent briefing regarding the issues before the court.

The court, in the careful exercise of its discretion, finds no need to appoint counsel for Mr. Redcorn in these proceedings. Mr. Redcorn's motion for appointment of counsel will be denied.

Rulings

After careful consideration, Mr. Frost's and Mr. Redcorn's motions to vacate judgment and sentence pursuant to 28 U.S.C. § 2255 are each **DENIED**.

Mr. Frost's and Mr. Redcorn's motions for an evidentiary hearing are also each **DENIED**. Mr. Redcorn's motion for appointment of counsel is **DENIED**.

Dated this 4th day of March, 2009.

/s/ S P Friot
STEPHEN P. FRIOT
UNITED STATES
DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

UNITED STATES OF AMERICA,	)
Plaintiff,	) Case No. 05-CR-001-SPF
vs.	) (Civil Action No. 08-CV-620, Frost)
WAKON IRON REDCORN, JR., and BRADLEY N. FROST,	) (Civil Action No. 08-CV-636, Redcorn)
Defendants.	)

JUDGMENT

In accordance with the court's order of this date, judgment in these proceedings, brought under 28 U.S.C. § 2255, is entered in favor of the plaintiff, United States of America, and against the defendants, movants Wakon I. Redcorn, Jr. and Bradley N. Frost.

Dated this 4th day of March, 2009.

/s/ S P Friot
STEPHEN P. FRIOT
UNITED STATES
DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF OKLAHOMA

UNITED STATES OF AMERICA, Plaintiff, v. WAKON IRON REDCORN, JR. and BRADLEY N. FROST, Defendants.	)	Case No. 05-CR-001-SPF (Civ. No. 08-CV-620, Frost) (Civ. No. 08-CV-636, Redcorn)

ORDER

Defendants Bradley N. Frost and Wakon Iron Redcorn, Jr., have filed Notices of Appeal (doc. nos. 221 and 224, respectively) with respect to this court's denial of defendants' motions pursuant to 28 U.S.C. § 2255. Both defendants have filed a request for a certificate of appealability (COA) under 28 U.S.C. §2253(c). (Mr. Frost's request at doc. no. 222, Mr. Redcorn's request at doc. no. 225.)

A defendant is entitled to a COA only upon making a substantial showing of the denial of a constitutional right. *See* 28 U.S.C. §2253(c)(2). A defendant can make such a showing by demonstrating that the issues he seeks to raise are deserving of further proceedings, debatable among jurists of reason, or subject to different resolution on appeal. *See Slack v. McDaniel*, 529 U.S. 473, 483-84 (2000) ("[W]e give the language found in § 2253(c) the

meaning ascribed it in [*Barefoot v. Estelle*, 463 U.S. 880, 893 (1983)], with due note for the substitution of the word 'constitutional.'"). "Where a district court has rejected the constitutional claims on the merits, . . . [t]he petitioner must demonstrate that reasonable jurists would find the district court's assessment of the constitutional claims debatable or wrong." *Id.* at 484. When a prisoner's habeas petition is dismissed on procedural grounds without reaching the merits of the prisoner's claims, "a COA should issue when the prisoner shows, at least, that jurists of reason would find it debatable whether the petition states a valid claim of the denial of a constitutional right and that jurists of reason would find it debatable whether the district court was correct in its procedural ruling." *Id.*

As described by defendants and as understood by this court, the issue as to which defendants seek a certificate of appealability is whether defendants were denied effective assistance of appellate counsel in violation of the Sixth Amendment to the United States Constitution.

The court finds and concludes that both of the defendants have made the requisite showing. Accordingly, Mr. Frost and Mr. Redcorn will each be granted a certificate of appealability, and the motions for same are **GRANTED**.

IT IS SO ORDERED this 18th day of March, 2009.

/s/ S P Friot
STEPHEN P. FRIOT
UNITED STATES
DISTRICT JUDGE

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

UNITED STATES OF AMERICA, Respondent-Appellee, v. BRADLEY N. FROST, Petitioner-Appellant.	No. 09-5034
UNITED STATES OF AMERICA, Respondent-Appellee, v. WAKON IRON REDCORN, JR., Petitioner-Appellant.	No. 09-5035

ORDER

(Filed Apr. 28, 2010)

Before **TACHA, GORSUCH, STAMP,*** Circuit Judges.

Appellants' joint motion for attorney discipline is denied.

* The Honorable Frederick P. Stamp, Jr., Senior United States District Judge for the Northern District of West Virginia, sitting by designation.

Appellants' joint petition for rehearing is denied.

The petition for rehearing en banc was transmitted to all of the judges of the court who are in regular active service. As no member of the panel and no judge in regular active service on the court requested that the court be polled, that petition is also denied.

Entered for the Court,

/s/ Elisabeth A. Shumaker
ELISABETH A. SHUMAKER, Clerk

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT
OF OKLAHOMA

No. 05-CR-001-SPF

UNITED STATES OF AMERICA,

Plaintiff

vs.

BRADLEY N. FROST,

Defendant

Motion to Vacate Judgment and Sentence and Discharge the Defendant Pursuant to 28 U.S.C.§2255 and Supporting Brief

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(Filed Oct. 20, 2008)

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ATTORNEY FOR PETITIONER
BRADLEY N. FROST

October 20, 2008

* * *

AFFIDAVIT OF ROBERT NIGH, JR.

State of Oklahoma)
) ss:
County of Tulsa)

I, Robert Nigh, Jr., being of sound mind and legal age, do hereby state under oath:

1. I am a licensed attorney and have been a member of the Oklahoma Bar Association since 1986.

2. I was one of the trial attorneys and then was appointed as appellate counsel for Bradley N. Frost, in *United States v. Bradley N. Frost*, Case No. 05-CR-001-SPF, in the United States District Court for the Northern District of Oklahoma.

3. I prepared the initial draft of the Defendant's opening brief in the Tenth Circuit and requested additional "words" from the panel. This request was denied. As a result, I edited the brief and inadvertently deleted the entire text of the argument portion of the sufficiency of evidence proposition relating to Count One. The portion of my brief that was edited out of the opening brief is attached hereto as Attachment A. While I intended to shorten the argument to comply with the word limitation, I had no intention of deleting it entirely.

4. As a result of this oversight Appellants began the discussion of sufficiency of the evidence with reference to the wire fraud counts, and did not make a specific argument concerning Count One. This omission was inadvertent and was not a

strategic decision because I believed this to be the strongest claim which had a reasonable chance of success.

4. In order to meet the word count requirement I should have shortened the factual statement, the argument on the sufficiency of the indictment and the proposition regarding preclusion by the *McCarran-Ferguson Act*, 15 U.S.C. § 1012(b).

Further affiant sayeth naught.

/s/ Robert Nigh, Jr.
Robert Nigh, Jr. OBA #11686

Subscribed and sworn to before me this 15th day of October, 2008.

/s/ Judy C. Blakemore
Notary Public

My commission expires:

8/16/11
No. 07007920

August of 2001 and the second Receivership Hearing in 2001, Ms. Burnett learned she had been duped by Mr. Silverstein. (Transcript p. 164.)

Ms. Burnett believed that had the Receivership occurred in August of 2001, Heritage National might have thrived and might still be in business today. Because of the delay and Steve Silverstein's ability to continue stealing money from the company, it ultimately failed. (Transcript pp. 167-168.) Mr. Silverstein took about $225,000 from HNIC during the time Darrell England was appointed by the Commissioner as the supervisor for HNIC. (Transcript p. 168.)

The Oklahoma Insurance Commission Report of June 22, 2001 indicated the company had a negative capital surplus of $100,000. If Mr. Silverstein had not taken the $2.6 million, the company's capital surplus would not be negative. (Transcript p. 197.) Ms. Burnett testified that her report filed with the Oklahoma Insurance Department was wrong concerning the amount owed by Mr. RedCorn, and was wrong in many other respects. Most of the inaccuracies were the result of being misled by Steven Silverstein. (Transcript p. 205.)

III. ARGUMENT.

A. The Government's evidence did not establish Heritage National Insurance Company was a healthcare benefit program.

Count One of the Indictment alleges that Mr. Frost and Mr. RedCorn "did knowingly and willfully embezzle, steal, or otherwise convert to the use of a person other than the rightful owner and did intentionally misapply, approximately $1,264,000 of the monies, funds, premiums, credits, and other assets of HNIC, *a healthcare benefit program as defined in Title 18, United State* [sic] *Code, § 24(b).*" (Indictment at p. 4 *emphasis supplied.*) Title 18 U.S.C. § 24(b) provides:

> As used in this Title, the term "healthcare benefit program" means any public or private *plan or contract*, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.

Id. (emphasis supplied.)

The evidence at trial was that HNIC was an insurance company, but it was not a plan or a contract. The proposition that Heritage National was not a healthcare benefit plan is given weight by the provisions of the Oklahoma Statutes. Title 36 O.S. § 103 provides: "'Insurer' includes every person

engaged in the business of making contracts of insurance or indemnity." The distinction between an insurance company and a healthcare benefit plan is further demonstrated by other provisions of the Oklahoma Statutes. Title 36 O.S. § 6060.3(g), which provides:

> As used in this section, "Health Benefit Plan" means individual or group hospital or medical insurance coverage, and not for profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, any program funded under Title IX of the Social Security Act, or such other publicly funded program, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under Federal ERISA provisions.

Id. Other provisions of the Oklahoma Insurance Code rely upon this definition of health benefit plan in order to identify the plans to which certain mandatory health benefits must be provided. For example, Title 36 O.S. § 353 defines "health benefit plan" in accordance with the terms of subsection G of § 6060.3 of Title 36. Under the provisions of Title 36 O.S. § 353, a health benefit plan may be required through official action to permit a person covered to obtain a broad range of benefits, including services from a particular healthcare provider or to obtain a

particular type of healthcare treatment or service. None of the Oklahoma Statute provisions governing healthcare benefit plans relate to an insurance company as defined by Oklahoma Statutes.

Perhaps more importantly, the federal statutes do not define healthcare benefit program to include an insurance company. Title 18 U.S.C. §669 and Title 18 U.S.C. §24(b) were part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") "an extensive attack on frauds against *the healthcare industry.*" *United States of America v. Whited*, 311 F.3d 259, 264 (3rd Cir. 2002), citing *The Health Insurance Portability and Accountability Act of 1996*, Pub.L. No. 104-191, 110 Stat. 1936.

There is nothing in the language of the statute that indicates Congress intended to control the inner operations of an insurance company. While the plain language of the statute should control, the context in which the statute was enacted lends support to the proposition the conduct alleged in the Indictment does not fall within the provisions of 18 U.S.C. §669. *See Bailey v. United States*, 516 U.S. 137, 145 (1995) ("the meaning of the statutory language, plain or not, depends on context.").

House Report No. 104-747 submitted to support passage of the anti-fraud provisions of HIPAA, detailed the law enforcement concerns and the types of fraud intended to be addressed. The types of fraud enumerated included:

1. Submission of claims for services that are not needed, not provided, or overpriced;

2. Kick back schemes for referral of services;

3. Bribing doctors, other referral sources, improperly waiving Medicare co-payments, billing fraud, and billing for services not rendered, and for treatment that was not reasonable or necessary;

4. Performance of medically unnecessary tests on unsuspecting patients (the so-called "rolling labs" case);

5. Prescription drug fraud;

6. Submission of false claims to private insurance companies;

7. Staged automobile accidents and related casualty and health insurance fraud;

8. Telemarketing healthcare fraud schemes with deceptive practices in selling medical equipment.

(H.R.Rep. No. 104-747 at pp. 7-9).

Although Congress had ample opportunity to include an insurance company within the definition of a group health plan, it specifically chose not to do so. In HIPAA, Congress set forth different definitions for health plans and insurance companies:

> The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health

> maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a state and which is subject to State law which regulates insurance (within the meaning of section 1144(b)(2) of this title). *Such term does not include a group health plan.*

29 U.S.C. §1191b(b)(2) (emphasis supplied). Nowhere in the provisions of HIPAA are a health care benefit program or plan and an insurance company defined as the same.

It is fundamental that criminal statutes must be strictly construed against the government: "Ambiguity concerning the ambit of criminal statute should be resolved in favor of lenity." *Rewis v. United States*, 401 U.S. 808, 812 (1971). "This rule of narrow construction is rooted in the concern of the law for individual rights, and in the belief that fair warnings should be accorded as to what conduct is criminal and punishable by deprivation of liberty or property." *Huddleston v. United States*, 415 U.S. 814, 831, citing *United States v. Wiltberger*, 5 Wheat, 76, 95, 5 L.Ed.37 (1820) and *United States v. Bass*, 404 U.S. 336, 348 (1971). Because there is nothing in the statute or the legislative history to suggest the inner workings of an insurance company can be considered "a healthcare benefit program", the Indictment does not allege a crime under the provisions of 18 U.S.C. §669.

Further support for the proposition the Government has nor proven the elements of a

violation of 18 U.S.C. §669 can be found by reference to the types of cases prosecuted under the statute. Counsel for Mr. Frost and Mr. Redcorn can find no reported case in which the statute has been applied to the internal workings of an insurance company. Reference to the activities the statute was designed to address are instructive.

In *United States v. Whited*, 311 F.3d 259 (3rd Cir. 2002) the defendant, a receptionist for the Back Mountain Chiropractic Center, had deposited into her account checks from Blue Cross of Northeastern Pennsylvania. The United States Court of Appeals for the 3rd Circuit had no difficulty in finding that the Back Mountain Chiropractic Center was a healthcare benefit program under the provisions of 18 U.S.C, §24(b) because it was providing medical benefits. *Id.* at 263.

In *United States v. Heavy Runner*, 2002 W.L. 31133353 (9th Cir. 2002) the defendant was the assistant administrator of a nursing home, clearly a healthcare facility and healthcare provider, In the related cases of *Smith v. United States*, 2004 W.L. 2504381 (S.D.N.Y.), *United States v. Francis*, 2003 W.L. 1701978 (S.D.N.Y.), and *United States v. Weisz*, 2003 W.L. 1701984 (S.D.N.Y. March 31, 2003) the defendants stole checks payable to healthcare providers.

In *United States v. Miller*, 406 F.3d 323 (5th Cir. 2005) the defendant was the chief financial officer of Medical Pathway, an affiliate of Medical Select

Management. It is unclear from the opinion what type of medical care provider these corporations were, but there is no indication they were insurance companies.

In *United States v. Riza*, 267 F.3d 757 (8th Cir. 2001) the defendant stole nineteen checks from his employer, "a healthcare provider in Adina, Minnesota". (*Id.* at 757.) Counsel for Mr. Frost and Mr. Redcorn have been able to locate no case charged under §669 which is in any way similar to the instant case, or which alleges depletion of an insurance company's assets by its officers.

Additional support for the proposition that the assets of an insurance company are not part of a healthcare benefit program can be found in the provisions of the Employee Retirement Income Security Act, 29 U.S.C. §1001, *et seq.* 29 U.S.C. §1101(b)(2) provides:

> In the case of a plan to which a guaranteed benefit policy is issued by an insurer, the assets of such claim shall be deemed to include such policy, but shall not, solely by reason of the issuance of such policy, be deemed to include any assets of such insurer. For purposes of this paragraph:
>
> (A) The term "insurer" means an insurance company, insurance service, or insurance organization, qualified to do business in the state.

> (B) The term "guaranteed benefit policy" means an insurance policy or contract to the extent that such a policy or contract provides for benefits the amount of which is guaranteed by the insurer. Such term includes any surplus in a separate account, but excludes any other portion of a separate account.

Id.

In Mack Boring & Parts v. Meeker Sharkey Moffitt, 930 F.2d 267 (3rd Cir. 1991), the United States Court of Appeals for the Third Circuit held that funds placed in an insurance company's general account, received as premium payments by an employer, do not constitute plan assets. The Court explained:

> A major pronouncement by the Department of Labor, which is the federal agency in charge of overseeing ERISA, also buttresses our interpretation of §401(b)(2)(B). Interpretative Bulletin 75-2B (IB 75-2) provides:
>
> > (b) Contracts or Policies of Insurance. If an insurance company issues a contract or policy of insurance to a plan and places the consideration for such contract or policy in its general account, the assets in such account shall not be considered to be plan assets. Therefore, a subsequent transaction involving the general asset account between a company will not, solely

> because the plan has been issued such a contract or policy of insurance, be a prohibited transaction.

29 C.F.R. 2509.75-2 (1982).

> As this regulation succinctly evidences, the Department of Labor, consistent with the result we reach today, does not consider general account assets held pursuant to insurance contracts to be plan assets.

Id. at 276 (interpreting 29 C.F.R. 2550.401(b)(2)(B)).

For the same reason, the general assets of HNIC cannot be considered a healthcare benefit program, While the policies themselves might be considered such programs, the assets of the insurance company itself cannot. Thus, the Government has not proven a violation of 18 U.S.C. § 669.

The Government is likely to argue that because Medicare and Medicaid are Healthcare Benefit Programs, HNIC must be one as well. The argument is fundamentally flawed.

Medicaid is by definition a healthcare benefit program:

> Medicaid is a cooperative federal-state program through which the federal government provides financial assistance to states so that they may furnish medical care to needy individuals. . . . The *state plan* is required to establish, among other things, a scheme for *reimbursing healthcare providers*

> *for the medical services provided to needy individuals.*

Wilder v. Virginia Hospital Association, 496 U.S. 498, 502 (1990) (emphasis supplied).

Medicare is also a healthcare benefit program by definition:

> Medicare is a federally subsidized *health insurance program* for the elderly and for persons with certain disabilities that is administered by CMS and private contractors.

United States v. McGovern, 329 F.3d 247, 248 (1st Cir. 2003).

While Medicaid and Medicare can be considered "plans" which would meet the definition of a healthcare benefit program under the Act, a private insurance company such as HNIC simply cannot be considered a "plan".

United States v. Lucien, 347 F.3d 45 (2nd Cir. 2003) cited by the government in support of the proposition HNIC is a healthcare benefit program, also misses the mark. *In Lucien,* the Court held the New York State no-fault automobile insurance *program* was a healthcare benefit program within the meaning of Title 18, United States Code Section 24(b). The Court did not hold that the insurance companies, bound by insurance contracts purchased by vehicle owners were healthcare benefit programs. It was the

contracts themselves which were the medical benefit programs implicating the federal statute.

This Court stated:

> The statute provides quite simply that "*any* public or private *plan or contract* . . . under which *any medical benefit*, item, or service is provided to any individual" qualifies as a "health care benefit program," 18 U.S.C. §24(b) *(emphasis added)*.
>
> In the instant case, private insurers – bound by insurance contracts purchased by vehicle owners pursuant to the No-Fault Act's requirement that vehicle owners maintain a liability insurance policy that provides coverage for automobile accident injuries regardless of fault – reimbursed various medical providers for fraudulently billed medical expenses that were incurred on behalf of Yves Baptiste and the other two defendants. Because Yves Baptiste – as well as Policia Baptiste and Guerline Dormetis – received *a medical benefit* as a result of the vehicle owners' no-fault *insurance contracts*, a health care benefit program is, under the statutory definition of §24(b), plainly implicated.

United States v. Lucien, 347 F.3d 45, 52 (2nd Cir. 2003) *(emphasis in original)*. Mr. Frost and Mr. Redcorn submit the insurance contracts at issue in *Lucien*, for the health care benefit programs, not the insurance company itself. For this reason *Lucien* is distinguishable from the instant case.

Simply stated, the Government has failed to establish Heritage National Insurance Company was a Healthcare Benefit Program, and the elements of Title 18 United States Code Section 996 were not proven. The Judgment of Acquittal should be granted for Count One.

B. The evidence at trial has not established wire fraud in violation of 18 U.S.C. § 343 as alleged in Counts Two through Five of the Indictments.

* * *